DOCUMENT RESUME

ED 171 886 UD 019 459

AUTHOR Martinez, Floyd H.
TITLE Close Encounters of the Worst Kind: The Mental Health Care of Minorities.
PUB DATE [79]
NOTE 20p.; Paper presented at the ADAMHA Conference on Minority Mental Health (Denver, Colorado)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Acculturation; *Cultural Differences; Ethnicity; *Health Needs; *Health Services; *Majority Attitudes; *Mental Health; *Minority Groups; Professional Training; Psychiatric Services; Racial Discrimination; Social Differences; Social Discrimination

ABSTRACT

There are many contributing factors to the mental health problems of minority groups. For example, the intergroup and intragroup diversity that exists between and among minority groups has not been recognized and controlled for by social and behavioral scientists. There are also certain social-psychological factors which predispose these groups to emotional disturbance and mental illness. Among them are the common experience of being conquered peoples, the assimilation-acculturation process, and their ethnic minority status. Discrimination and prejudice, poverty, cultural-linguistic barriers, undereducation, and poor physical health are other contributing factors. As a result of these factors, minority group members have a high incidence of mental health problems. In addition, basic misconceptions held by professionals and mental health workers lead to non-treatment or inappropriate treatment of minority group patients. There are also problems with diagnosis and psychological testing of minorities. Some advances have been made, but training institutions need to increase the number of minorities trained and their curriculum must account for cultural and ethnic differences. (Author/EB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
F. H. Martinez

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

ED171846

CLOSE ENCOUNTERS OF THE WORST KIND:
The Mental Health Care of Minorities

Floyd H. Martinez, Ph.D.
Executive Director
Mental Health Center of Boulder County, Inc.

Presented
ADAMHA Conference on Minority Mental Health
Denver

Introduction:

It would be presumptuous to assume that the state of the art in minority mental health can be covered adequately in one presentation, or that a member of one minority group can articulate the issues clearly and sensitively for all groups. The best that can be hoped for is an honest effort to outline some of the fundamental problems that seem to cut across all people of color in contemporary United States society. Drawing on a rather extensive review of the literature and on my personal experiences as a clinicial, researcher, administrator and federal bureaucrat, I have yet to encounter a true expert in this field. We all hold a piece of the puzzle, but no one has the complete picture. With such a state of affairs, I would propose that we adopt a perspective in which we all share what we know in a climate of cooperation and willingness to learn, and that we attempt to present the issues with the aim of minimizing the errors in the care of our peoples.

"People of color" is a phrase that I will occasionally use in speaking of the entire spectrum of what we have also called "minority groups" because it appears to cover most of the diversity that exists among us. It is this intergroup and intragroup diversity that must be continually maintained in our conscious awareness as we attempt to piece together the puzzle. Each group has preserved some of the original culture; the ethnicity that is interpreted as more than a uniqueness defined by national origin, race, geography, language or religion. It provides at least some of the conscious and unconscious processes

UD019459

that comprise our sense of identity, security and continuity with the ancients. It provides the seeds for the answer to the question, "Who am I?" Every group can trace its own unique history in the struggle for equality and each group feels its own presence in the context of the United States social structure. Octavio Paz, (1962) describes the experience for Chicanos; Deloria, (1970) provides a powerful account of the American Indian experience; and Kim, (1976) offers us an understanding of the struggle and coping mechanisms of Koreans in this country.

Intragroup differences occupy an equally wide spectrum that expresses level of acculturation and assimilation, regional differences, tribal or national origin, and other dimensions of personal variability. For example, there are about one million American Indians in the United States representing over two hundred tribes. The population we label Asian Americans contains peoples from vastly diverse cultures: Japanese, Vietnamese, Korean, Chinese, as well as Pacific islanders from the Philippines, Hawaii, Guam, Tonga and many more. Hispanics comprise three main groups; Chicanos, Puertoriquenos and Cubanos, but there are also large numbers of Central and South Americans. These groups differ greatly in their belief systems, family patterns, political views and even language. Although Spanish is the core language, many dialect forms are spoken, such that communication across groups is not always a simple matter. Blacks also experience wide differences in terms of regional and national origin. Patterson, (1972) gives a vivid differentiation between Blacks in the West Indies and Blacks in the mainland United States. An appreciation and thorough understanding of these group differences is a primary prerequisite for the conduct of research and for the delivery of services to people of color.

The failure of social and behavioral scientists to recognize and control for extensive inter and intra group differences has led to a body of literature

replete with errors of conceptualization, design, analysis and interpretation. At the root of the problem is the apparant lack of appropriate theoretical perspective(s) from which to address basic and applied research questions. Numerous writers, (eg. Padilla and Ruiz, 1973), have been critical of the "state of the literature", citing problems in unwarranted assumptions, inadequate controls, inappropriate statistical tests and biased conclusions. Two of the mose pervasive shortcomings appearing in the literature are 1) the tendency to homogenize minority group populations and 2) the propensity to use Anglos as the reference group against which minority group dimensions are measured. Not only are the classic studies, (eg. Hollingshead and Redlich, 1958; Srole, et. al., 1962), guilty of inadequate designs, but much of the more recent literature is similarly compromised by inadequacies of assumptions and design. Such a state of affairs places a heavy responsibility on the reader of the literature to be alert to the general problems of design and highly sensitive to errors in interpretation.

Predisposing Factors:

In analyzing the state of the art in the mental health of minority groups in the United States, certain social-psychological factors may be viewed as constituting a common body of experiences that predispose all groups to emotional disturbance and mental illness. First, there is the common experience of being <u>conquered peoples:</u> Of having a history of being overpowered; militarily, economically, culturally and/or geographically. Clearly each group's history with the dominant United States culture is unique yet each group has suffered a similar impact - - the impact on the collective self-concept.

The Black experience in slavery and the continuing struggle for full equality is among the most blatant examples of an oppressive conquest of one group by

another in United States history. As vividly depicted in Alex Haley's Roots, the epic struggle for freedom has woven much of the cultural fiber of Black America, both in terms of strengths and debilitating effects. Similarly, the Native American experience is one that began with geographic encroachment followed by a systematic military conquest, near extinction and subsequent attempts to erase the cultural heritage of Indian nations. Some Indian leaders, (eg. H.C. Townsley) have noted the continuing role of the Federal government in what amounts to cultural genocide through programs such as the BIA. Among Hispanics, each subgroup has experienced "conquest" in idiosyncratic ways. Chicanos, the largest of the Hispanic subgroups can point to several centuries of resistance to Anglo military, economic and cultural domination in the Southwestern United States. The Treaty of Guadalupe Hidalgo of 1848 marks the end of the military conflict, but the war against oppression and exploitation continues until the present time. Deep-seated problems in immigration, labor, education and political participation maintain a state of tension between the Chicano communities and the established dominant society. Puerto Ricans struggle with many of the same issues as Chicanos; e.g. discrimination, inappropriate education, inequality under the law, etc. In contrast, however, the historical aspects of their domination center around the military and economic domination of Puerto Rico as a commonwealth. Cubanos in this country are refugees of an internal revolution, but the psychological impact is comparable to other Hispanic groups. Finally, Asian Americans have immigrated for many reasons, but discrimination and economic exploitation remain central to the Asian struggle. From the early exploitation as a cheap source of labor to the detention camps during World War II, Asians have paid the psychological price of conquest.

Various authors have noted the negative effects of Anglo domination on the

collective self concept of minority groups, (e.g. Utsumatsu, 1971; and Clinard, 1970). The self concept acts as a determinant in our sense of power, striving and importance, "and once established it apparantly provides a sense of continuity over space and time, and is defended against alteration, diminution and insult", (Clinard, 1970, p. 332). If we accept such a conceptualization of the self-concept, the notion of "conquered peoples" proposed above may be viewed as a predisposing, historical factor in the emotional disruption index of minority groups in the United States.

A second and closely related factor or social-psychological dimension is the assimilation - acculturation process. Much has been written about the effects of assimilation and acculturation on the sense of identity of the minority group person. The clinical literature points to the importance of solid anchorages of personal identity in emotional stability. The identity crisis, (a la Erikson, 1968), may be viewed as a clinical manifestation of assimilation and acculturation, dimensions that all minority persons experience to a greater or lesser extent.

Ethnic minority status in the context of U.S. society may be viewed as a third basic stressor on the mental health of people of color. Each report of the minority sub-panels of the President's Commission on Mental Health has mentioned the effects of minority status on mental health. Discrimination and prejudice, poverty, cultural-linguistic barriers, undereducation and poor physical health are among the most commonly mentioned variables that contribute to emotional stress and mental disturbances.

Discrimination and Prejudice -- Many contemporary writers have elucidated the effects of discrimination, prejudice and racism on mental health, (e.g. Willie, et. al. 1973; Shapiro, 1975; Martinez, 1975). The pervasive effects of racism are felt by minority people not only in terms of the psychological impact on the individual, but also in terms of effects on the structure and clinical

function of human service systems. The evidence for the psychic damage of racism comes partly from empirical findings and from the vast reservoir of clinical experience with children and adults. It is also recognized that racism affects not only the victim of racist behavior, but the holder of racist attitudes. Cooper, (1973), in dealing with this issue states, "Clearly racism bites deeply into the psyche. It marks all victims - Blacks and Whites - with deep hurt, anger, fear, confusion and guilt." Similarly, racist institutional practices have a profound effect on nearly every aspect of the lives of people of color; from the educational system to the administration of justice, to the delivery of health and mental health care. The effect generally is that minorities get less quantity, poorer quality and they pay a higher economic and psychological price. While it is true that the more blatant acts of racism have been reduced through legal efforts and a greater degree of understanding, the more subtle forms continue to flourish.

Poverty - - Social scientists and popular writers have established the state of poverty as a culture with all the concomitant patterns of conduct and commonly employed adaptive techniques ordinarily ascribed to the concept of culture in the sociological literature, (Lewis, 1966). It is also well established that membership in the so called culture of poverty increases the probability of needing mental health services, (e.g. Hollingshead and Redlich, 1958). Simply stated, being poor within the greater context of an affluent society places a myriad of mental stresses on the individual - - hunger, worry, disgust, shame, alienation, anger, etc., which can constitute the clinical antecedents of mental disturbance. It is similarly established that minorities constitute a disproportionate percentage of persons living in poverty. Every index of the unemployment rate shows minority persons suffering a greater degree of unemployment or underemployment

than non-minorities. In many instances the minority unemployment rate tends to be more than double the overall rate and in some areas, as in some Indian reservations, the unemployment rate exceeds 85%. In speaking to this issue, the preliminary report of the President's Commission on Mental Health states, "Vast numbers of Americans experience the alienation and fear, the depression and anger associated with unrelenting poverty and the institutionalized discrimination.... The Nation must realize the terrible emotional and mental damage that poverty and discrimination cause."

Cultural-Linguistic Barriers - As stated earlier in this presentation, each minority group has managed to preserve some aspects of the culture of origin. In some, all but the rudiments of names and superficial memories has been lost, while in others the language, patterns of behavior, and allegiance still belong to the mother culture. Among the most enduring have been some of the Indian pueblos of New Mexico and some Chicano communities of the Southwest. In these instances, cultural patterns including language have remained intact despite continual Anglo cultural encroachment. Recent immigrants from Mexico, South America and Southeast Asia, of course bring their cultural ties intact to the barrios and "chinatowns" of the United States. These cultural and linguistic patterns collide with the capricious, ethnocentric, monolingual mentality of U.S. society. It is indeed a curious situation that one of the most developed countries in the world refuses to speak more than one language! Available human services naturally reflect the "cultural singularism" of the society at large such that services in the language and cultural context of the minority group client are rarely available. Even more importantly, however, is the fact that the more visible the person's alien culture is, the more susceptible he or she is to discriminatory practices. Thus, speaking English with a heavy foreign accent, an indication that the person

is fluent in another language, is a liability.

Epidemeological Issues:

The preliminary report of the President's Commision on Mental Health indicates that close to 15% of the nations population is in need of professional mental health services intervention, which computes to between 20 and 32 million Americans. The cost of providing mental health services is currently about $17 billion per year, although the cost of emotional disturbance and mental illness to the gross national product exceeds an additional $20 billion. National estimates indicate that about four million people suffer from schizophrenia or profound depressive disorders. About 30% of all hospital beds are occupied by patients with mental health problems. One of the most disturbing trends is the alarming increase in adolescent suicide, depression and drug and alcohol abuse.

Data on minority group disturbances is difficult to isolate since agencies that compile statistics have not collected information according to racial and ethnic groupings. It is generally agreed however, that because of a variety of predisposing conditions, (some of which have been mentioned above), minority group members have a higher prevalence and incidence of mental health problems. Taking a rough population estimate of 44 million minority persons, (25 million Blacks, 15 million Hispanics, 2.5 - 3 million Asians and 1 million Indians), a 15% level of disruption would give 6.6 million persons in need of professional mental health care. We can assume the actual figure is much higher - perhaps as high as 10 million.

Information on the various rates of specific mental disorders among the four primary ethnic groups is even more difficult to obtain and the information available must be interpreted with considerable caution. We do know, mostly from clinical experience, that depression, psychosomatic symptomatology and alcohol abuse tend to be disproportionately high among minority group clients. For example, alcoholism

among some Indian groups is a very serious problem as judged by deaths from cirrosis of the liver and other indicators. Also, despite the somewhat romanticized notions about the place and strength of the Chicano family, indications are that family disruption within this group is disproportionately high. A considerable amount of literature has appeared on various Hispanic indigenous disturbances such as mal ojo, susto, ataque, aire, etc. While these disturbances do occur, the impression (of this writer) is that there is more romance than fact in terms of the comparative prevalence of these disorders.

Giordano and Giordano, (1976) cite the work of Rabkin and Struening with regard to the prevalence and incidence of mental disturbance among ethnic groups and offer the following useful summary:

1. It is generally acknowledged that psychiatric disorders are not distributed randomly throughout populations, but tend to be concentrated within definable subgroups. The major dimensions historically associated with such variations are those of ethnicity, social class and immigration which are characteristically interrelated.

2. Psychiatric admission rates, diagnosis, length of hospitalization and facility utilization patterns vary among ethnic groups. Considerably more information is available on racial differences than on variations among white ethnic groups.

3. Ethnic groups vary markedly in terms of social class, time of migration, age and sex composition, education and occupational level. Many studies of the relative rates of mental disorders between ethnic groups do not evaluate their samples in terms of these characteristics making it difficult to draw conclusions about the relative influence of ethnicity per se on rates on diagnosed mental illness.

4. Knowledge in this area is based on studies which vary considerably on such factors as: a) the criteria for mental disorders; b) the selection of samples; c) definitions of ethnicity and mental illness; and d) methods of data analysis. Thus conclusions about the relationships of rates of various mental disorders with ethnic characteristics of defined populations are tentative and must be qualified.

Encounters With The Service System:

A considerable body of literature has been generated on minority perceptions of mental illness and on the utilization -- or non-utilization -- of mental health services. The trinity of laments in this regard points to 1) the non-availability of services in areas where minority population are concentrated; 2) the inaccessibility of existing services due to various language, geographic, institutional and philosohpical barriers that prevent minorities from utilizing facilities and; 3) the inappropriateness of many existing services due to their lack of sensitivity to minority cultural differences. In this regard, Padilla and Ruiz, (1973) cite the work of Torrey in which he lists several variables that contribute to under-utilization and lower quality treatment. Among these are 1) geographical isolation, 2) language differences, 3) classbound values, in which middle class therapists deal with lower class clients and 4) culture bound values, in which therapists from one cultural perspective treat clients from another culture resulting in a low-accuracy therapeutic relationship.

Many basic misconceptions are held by professionals and mental health workers about minorities that lead to non-treatment or inappropriate treatment. Some workers believe that minorities have a propensity toward malingering and thus tend to disregard or take lightly the disturbed behavior of clients. This view is especially visible among staffs of inpatient units.

Secondly, there is a widespread belief that the strengths of the minority family provide for the support and therapeutic needs of the individual and hence, there is no need for the formal system's intervention. At least part of the responsibility for this myth rests with minority writers who have examined the supportive and facilitative role of the traditional extended family, but have neglected to clearly articulate the modern family's confused, disrupted and often chaotic state. The clinical evidence strongly suggests that due to such disruptive influences as migration, differential assimilation and acculturation, economic stress, separation and divorce, etc., the role of the minority group family as a stable support system has been considerably eroded.

A third misconception pertains to the degree to which minorities utilize folk treatment techniques and faith healers. A significant amount of literature has appeared on such practices as espiritismo, curanderismo, medicine men and other traditional or folk systems of treatment suggesting that these are widespread, universally accepted alternatives. While there are numerous examples of such systems providing a useful and effective service, (e.g. Navajo Mental Health Service, Chinle, Arizona), they generally do not represent a readily available substitute for careful, responsible and effective mental health programming on a pluralistic basis. In many instances where minority clients do utilize folk and faith healers, they also seek services from public mental health facilities.

A final misconception to be noted here is the subtle and insidious belief that minority clients are not good candidates for individual, (insight), therapy: That they are not highly verbal, insightful and motivated, (VIM's) and thus should alternately be treated with drugs and other more concrete modelities. Or they should be assigned to lesser trained, (and less expensive), mental health workers. As a result, it is not uncommon for the DUDS, (dull, unmotivated, de-

pendent and submissive), to receive differentially poorer treatment.

It is important to recognize that these and other misconceptions about minorities often serve to relieve therapists and administrators of systemic guilt and, ipso facto, to allow publically funded programs "off the hook" in serving people of color. An argument could be made that it may be better not to be served at all than to encounter services that are actually harmful to the client. While such an argument may have some merit, the failure to provide adequate services as early as possible often leads to a deterioration of the condition until more restrictive and expensive services are required. And, some data does suggest that minorities are relatively over-represented in the more acute diagnostic categories, (eg. Gross et. al, 1969; Shapiro, 1975; Maas, 1976).

No review of the state of the art would be complete without attention to the general problem of misdiagnosis and the specific problem of the psychological testing of minorities. In various ways misdiagnosis is one of the most destructive aspects of minority group contact with the service system: Indeed these are encounters of the worst kind. The misdiagnosis, (not just mis-labeling but misunderstanding), not only serves to misappropriate treatment resources and the client's time and energy, but more importantly, it provides the possibility for serious damage to the client. To illustrate the point, a young Mexican woman involved in a custody dispute with her Anglo husband was evaluated, (and tested), by an Anglo psychologist who blatantly disregarded several linguistic and cultural factors. (A subsequent examination of the attitudes of the examiner, the conditions under which she was examined, the appropriateness of test used, the misinterpretation of test profiles, etc. strongly suggested an alternate and more "favorable" hypothisis of the woman's mental status). The resulting diagnostic impressions supplied to the court became the evidential basis for her instability, unfitness

as a mother, and consequent loss of her children. Exasperated by what she considered to be a disasterous error she began to exhibit "real" psychotic symptoms. Many weeks of intensive intervention have had to be invested in helping her through the traumatic experience. Yet none of the "predictions" of the initial diagnosis have been borne out.

Shapiro, (1975); Maas (1976); Willie, et.al., (1973) and many others have dealt with the problems of misdiagnosis and differential diagnosis. People of color tend to be assigned psychotic or psychopathic diagnoses for the same symptoms that whites characteristically receive neurotic labels, (Gross, 1969). This writer has been dismayed by the propensity of Anglo clinicians to assign a character disorder diagnosis to minority clients in the face of equivocal data for other conclusions.

The use of psychological test with minorities has received extensive attention in the literature. Norming issues; the question of paper and pencil experience; linguistic barriers and other cultural factors; and genetic factors are some of the notable issues. The controversy over testing has not been confined to the technical debates of psychologists but has entered the legal arena as well. Notable among the court decisions is Hobson vs. Hansen in which the Washington D.C. school system was ordered to abolish its educational tracking program because of the discriminatory effects of standardized tests.

As early as 1932, George I. Sanchez raised issues pertaining to the use of test of Spanish speaking children, (Sanchez, 1932). More recently Jane Mercer has done extensive work with Chicano school children in California in an effort to identify variables that affect the measurement of I.Q. (e.g. Mercer 1972). Similarly, Robert Williams has contributed an impressive number of publications dealing with the testing of Blacks, (e.g. Williams, 1972). Wright and Isenstein, (1975) provide an excellent review of this area. The general impression gained from the

literature is the blatant disregard of basic principles of test validity and reliability by school systems and practitioners; the inappropriateness of a vast number of instruments for use with minority clients; and the need for better ways of assessing intelligence, personality and mental status among minority group clients.

Summary and Conclusions:

A review of the precipitating, predisposing and contributing factors to minority group alcohol, drug abuse and general mental health problems raises many questions, some dispair and an occasional ray of hope. It is certainly not an easy arena to examine for it is vast, varied and intricately complex. Do we speak of minority groups, people of color, ethnic groups, or racial and ethnic groups? Indeed there are basic questions of group definition, group size and group names. Orientals are now Asians and Pacific Islanders; Indians are Native Americans or U.S. Indians; Negros are Blacks; and Mexicans and Spanish Americans are now Chicanos...maybe. Collectively the Spanish speaking, Spanish surnamed have gone from Latino to Hispanic, (with the "H" emerging from its traditional silence). It is exceedingly difficult to determine an accurate count of U.S. minority groups for they have been uncounted, miscounted and discounted by such agencies as the Bureau of the Census and the Bureau of Health Statistics.

The complexity begins to mount when one considers the between groups comparisons; minority vs. non-minority and one minority vs. another. Another complexity is added when one considers the tremendous intra-group differences. Two hundred tribes of Native Americans and Alaskans; Asians ranging from Northern China to Tonga; and U.S. Mexicans with cultural roots from every region of Mexico are but some of the variabilities to consider. The available information on each group ranges from rhetoric to well designed empirical findings, but the reviewer of the literature must be ever-wary of human frailties and technical shortcomings.

It is clear that there is much yet to be developed and understood about the mental health of minorities. We need to know more about:

1) The genetic influences on behavior and how these influences interact with specific ethnic group cultures. Arthur Jensen and others have raised serious questions about the role of heredity on measured intelligence; more attention needs to be paid to the mental health implications of inherited diseases such as sickle cell anemia; and the differential effects of heredity on schizophrenia, OBS and other disorders need more attention.

2) The effects of racism, prejudice and discrimination on child development, emotional disturbances and the service system. Much has been written on this subject but much more needs to be substantiated with good data.

3) The efficacy of blending modern treatment techniques with traditional and folk systems of care. The mythology must be cast aside and the true conditions need careful examination.

4) The inherent strengths of minority cultures. These need further evaluation and better articulation in order to maximize the utiligation of minority group resources.

5) Special problems that are more-or-less unique to minority populations. Among these are the effects on the development of minority children of various school practices and structures, such as BIA schools on Indian children, and the use of test to determine the program placement of minority children. The serious and increasing problem of alcoholism among Native Americans and other groups, and changing patterns of drug abuse are also special issues that need attention.

Shortcomings in the established mental health care system have been seen as contributing factors in this review. Both the lack of care and inappropriate care can have deleterious effects on the individual. Some of the evidence suggests that people of color are not served until the condition deteriorates to a crisis and the probability of the need for hospitalization is increased. The possible damaging effects of inappropriate treatment have been illustrated. The special problem of misdiagnosis, in its broadest sense, is viewed as central to various negative encounters with service providers. The dearth of well trained minority service providers and the inappropriate utilization of the limited supply contribute to the general quantity and quality of services problem. It is apparent that not only do training institutions need to increase the number of minorities trained but the general curriculum must account for cultural and ethnic differences. It is appalling to note how ethnocentric medical, psychological and social work training programs still are despite extensive efforts to effect changes.

Let me close with a ray of hope. The sweat, blood and tears of the last two decades have brought appreciable rewards. Some of the most blatant acts of racism and discrimination have been diminished and some sensitivity to minority needs has been brought about. As a society we have re-articulated the basic constitutional principles of freedom and equality. In our own field we have managed to pass legislation that speaks to the issues of cultural differences and bilingualism. Federal guidelines have managed to preserve the intent of the law reasonable well although little has been done about enforcement. The supply of minority mental health professionals has been increased and our institutional practices have improved. Granted we have a long way yet to go.

But perhaps the most positive aspect is that we as minorities have come a long way toward sorting through our own identity and position in U.S. society. The painful period of the sixties and early seventies; the marching, the rhetoric

and even the burning were for us to hear and see. It was, in a sense, our emancipation from the conquest. We have learned much about what we can do and what we must not do. We have worked through enough of our frustration and anger to see new possibilities and to form new alliances. A new spirit of coaltion between us and the responsive parts of the majority society, and more importantly, among us as minority groups, is emerging. We have learned that true brotherhood and sisterhood come in more than one color, and they can be said in more than one language.

REFERENCES

Clinard, M. - "The Role of Motivation and Self Image in Social Change in Slum Areas." In: Allen, V., ed. Psychological Factors in Poverty. Chicago: Markham Co.

Cooper, S. - "A Look at the Effects of Racism on Clinical Work". Social Casework, Vol. 54, P. 76 - 84, Feb. 1973.

Deloria, V. - We Talk, You Listen. New York: MacMillan and Co. 1970

Erikson, E. - Identity: Youth and Crisis. New York: W.W. Norton, 1968.

Giordano, J. and Giordano, G. - "Ethnicity and Community Mental Health." Community Mental Health Review, Vol. 1, No. 3, 1976.

Gross, H. et. al. - "The Effect of Race and Sex on the Variation of Diagnosis and Disposition in a Psychiatric Emergency Room." J.Nerv. and Mental Disease, 1969, 638 - 642.

Hollingshead, A. and Redlich, F. - Social Class and Mental Illness: A Community Study. New York: Wiley, 1958.

Kim, B.L. - "An Appraisal of Korean Immigrant Service Needs." Social Casework, 57, 1976; 139 - 148.

Lewis, O. - "The Culture of Poverty." Scientific American 1966, 215: 19 - 25.

Maas, I. - "Asians as Individuals: The Japanese Community". Social Casework, 57, 1956: 160 - 164.

Martinez, F. - Appropriate Mental Health Services for Chicanos: Is It Just a Question of Technology. Keynote address, annual Colorado Mental Health Conference. Snowmass, 1975.

Mercer, J. - IQ: The Lethal Label. Psychology Today: 6 (4), 1972.

Padilla, A. and Ruiz, R. - Latino Mental Health: A Review of Literature. Rockville: NIMH, 1973.

Patterson, O. - Die the Long Day. New York: Morrow, 1972.

Paz, O. - Labryinth of Solitude: Life and Thought in Mexico. New York: Grove Press, 1962.

Sanchez, G. - "Group Differences in Spanish Speaking Children: A Critical Review." J. of Applied Psychology, 16 (5): 549-558, 1932.

Shapiro, R. - "Discrimination and Community Mental Health." Civil Rights Digest, Fall, 1975.

Srole, L.; Langer, T.; Michael, S.; Opler, M.; and Rennie, T. - Mental Health in the Metropolis: The Midtown Manhatten Study. New York: McGraw-Hill, 1962.

Townsley, H.C. - The Epidemology of Minority Mental Health. Panel Presentation, WICHE Rocky Mountain Mental Health Conference on Minority Groups: Denver, April, 1978.

Uyematsu, A. - "The Emergence of Yellow Power in America." In Roots: An Asian American Reader, edited by A. Tachiki, E. Wong, F. Odo, Los Angeles: UCLA Press.

Williams, R. - "Abuse and Misuse in Testing Black." In: Jones, R., ed. Black Psychology. New York: Harper and Row, 1972.

Willie, C., Kramer, B., and Brown, B., editors - Racism and Mental Health. Pittsburgh: University of Pittsburgh Press, 1973.

Wright, B. and Isenstein, V. - Psychological Tests and Minorities. Rockville: NIMH, 1975.